

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06328

Reg. Dist. No... 302

## CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <b>Washington</b>		MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>		LENGTH OF STAY (in this place) <b>10 min.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Washington Co. Hospital</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		COUNTY <b>Washington</b>	
		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>		STREET (If rural, give location) ADDRESS <b>R.D. #5</b>	
3. NAME OF DECEASED (Type or Print) <b>Baby Boy</b>		(First) (Middle) (Last) <b>Baker</b>		4. DATE OF DEATH <b>June 20th 1951</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Single</b>	8. DATE OF BIRTH <b>6-20-51</b>	9. AGE last birthday yrs. <b>—</b>	If under 24 hrs. Months. Days Hours Min. <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Dowell Westley</b>		14. MOTHER'S MAIDEN NAME <b>Delores May Snyder</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <b>Prematurity -</b>		Delores M. Baker			
Antecedent cause(s) <b>776X</b>		INTERVAL BETWEEN ONSET AND DEATH			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>159</b>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5:40 P.M. 6-20-51</b> , to <b>5:10 P.M. 6-20-51</b> , that I last saw the deceased alive on <b>6-20-51</b> , and that death occurred at <b>5:10 P.M. 6-20-51</b> , from the causes and on the date stated above.					
SIGNATURE <b>Andrew Bapst</b>		ADDRESS <b>97 N.D. Hagerstown Md.</b>		DATE SIGNED <b>6-20-51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>6/21/51</b>		NAME OF CEMETERY OR CREMATORIAL <b>Bellview Cemetery</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <b>John J. Bowers</b>		LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR		ADDRESS <b>Andrew K. Coffman Hagerstown Md.</b>			

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MUN 25 1967

BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

06329

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Pennsylvania COUNTY Dauphin		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Hagerstown (in this place) 4 years			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harrisburg.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital			STREET ADDRESS 1208 Chestnut Street (If rural, give location)		
3. NAME OF DECEASED (First) William (Middle) Arthur (Last) Baptisti		4. DATE OF DEATH Month June 6, 1951 Day 19			
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb. 1, 1882	9. AGE last birthday 69 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor			10b. KIND OF BUSINESS OR INDUSTRY Fruit & Produce		
11. BIRTHPLACE (State or foreign country) Harrisburg, Pa.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Peter G. Baptisti			14. MOTHER'S MAIDEN NAME Susan Fidle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 278-18-0985 17. INFORMANT AND ADDRESS Dr. Arthur Baptisti Jr.-Hagerstown Md.		

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260X

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Broncho Pneumonia 4 days					
332X Antecedent cause(s) (b) Cerebral thrombosis 4 yrs.					
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerosis yrs.					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus - mild. 5 yrs.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from ..... , 1947, to JUNE 6, 1951, that I last saw the deceased alive on JUNE 6, 1951, and that death occurred at 11:35 P.m., from the causes and on the date stated above.  
 SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE PLACED	NAME OF CEMETERY OR CREMATORIUM Paxtang Cemetery	LOCATION (City, town, or county) Harrisburg, Pa. (State)
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
June 8, 1951		Lloyd A. Hoffman	John Poland Clear Spring, Md.	

VS. A.5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REF ID: A620

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JUN 11 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

06330

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY <b>Washington</b>		MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hagerstown</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Washington</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hagerstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wash. Co. Hospital</b>		LENGTH OF STAY (in this place) <b>Life</b>		STREET ADDRESS <b>1 South Mont Vallia</b>	
3. NAME OF DECEASED (Type or Print) <b>Data</b>		(First) (Middle) <b>R.</b>		4. DATE OF DEATH <b>June 22 1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>6-4-1884</b>	9. AGE last birthday If under 1 year Months <b>67</b> Days <b>0</b> Hours <b>18</b> Min. If under 21 hrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Maryland</b>	
13. FATHER'S NAME <b>Frank P. Alsip</b>		14. MOTHER'S MAIDEN NAME <b>Annie I. Robinson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT AND ADDRESS <b>Mrs. Leoda M. Hickey, Hagerstown, Md.</b>	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

443X  
 Immediate cause (a) *Cerebral thrombosis* 11 days  
 Antecedent cause(s)  
 Diseases or conditions, if any, giving rise to the above cause (b) *Hypertensive vascular disease*, yrs.  
 stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

 Yes  No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Jun. 21, 1951**, to **Jun. 22, 1951**, that I last saw the deceasedalive on **Jun. 21, 1951**, and that death occurred at **7:20 P.m.**, from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL OR CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>6-25-1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>	LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>	(State)
DATE REC'D BY LOCAL REG. <b>June 25, 1951</b>	REGISTRAR'S SIGNATURE <b>Blair Powers</b>	24. FUNERAL DIRECTOR <b>C. M. Suter &amp; Sons, Hagerstown, Maryland</b>	ADDRESS	

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JUN 27 1951

BURGESS

118  
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06331

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH: COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland WASHINGTON			
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Rural Big Spring (in this place) 28 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Big Spring			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Four Locks		STREET ADDRESS (If rural, give location) Four Locks			
3. NAME OF DECEASED (Type or Print)	(First) Harry	(Middle) Benjamin	(Last) Bowers		
4. DATE OF DEATH June 1, 1951	5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married		
8. DATE OF BIRTH Aug. 30, 1875	9. AGE last birthday 75 yrs.	If under 1 year Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY Farming Retired	11. BIRTHPLACE (State or foreign country) McCoy's Ferry, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Hart	14. MOTHER'S MAIDEN NAME Sarah Bowers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs. Ella E. Bowers- Big Spring, Md.	R.D.		
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) Coronary Occlusion Day Antecedent cause(s) (b) 420.1 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 94a					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 4/20/51	19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY June 4 1951 m.	INJURY OCCURRED White at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/31/51, 19....., to 6/1/51, 19....., that I last saw the deceased alive on 6/1/51, 19....., and that death occurred at 2 P.m., from the causes and on the date stated above. SIGNATURE J. S. Young M.D. Williamsport, Md. 6/2/51 DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE June 4-51	NAME OF CEMETERY OR CREMATORIAL Green Spring Chapel Cemetery	LOCATION (City, town, or county) Near Big Spring, Md.	(State)	
DATE REC'D BY LOCAL REG. June 4/51	REG. Local.	REGISTRAR'S SIGNATURE J. W. Murray	24. FUNERAL DIRECTOR D. Adriana V. Rawland	ADDRESS	Tolson

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BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06332

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown LENGTH OF STAY (in this place) 40 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown STREET ADDRESS Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Emily Cecelia Brown	(First) (Middle) (Last)	4. DATE OF DEATH 6 27 1951	(Month) (Day) (Year)
5. SEX Female Negro	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-6-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY At home	9. AGE last birthday 61 yrs.
13. FATHER'S NAME Cable Nichols		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	12. CITIZEN OF WHAT COUNTRY?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Mrs Alice Clinton Hagerstown
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause  216X	(a) generalised peritonitis	INTERVAL BETWEEN ONSET AND DEATH 4 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last  56a	(b) Gangrene of Sigmoid c Perforation	5 days	
	(c) Ovarian Cyst Lt; Twisted + gangrenous	4 yes +	
	Calculus of Bladder		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 6/25, 1951, to 6/27, 1951, that I last saw the deceased alive on 6/27, 1951, and that death occurred at 9:05 P.m., from the causes and on the date stated above. SIGNATURE Richard V. Hauser m.d. ADDRESS DATE SIGNED Richard V. Hauser m.d. Hagerstown, Md.			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 7-1-1951	NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Maryland
DATE REC'D BY LOCAL REG. No. 29-1857	REGISTRAR'S SIGNATURE Bhart Bozell John R. Johnson	24. FUNERAL DIRECTOR ADDRESS	

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JUL 1951

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## MARYLAND STATE DEPARTMENT OF HEALTH

06477

## CERTIFICATE OF DEATH

Reg. Dist. No.

306

1. PLACE OF DEATH COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Highfield		35 years		TOWN Highfield			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) William	(Middle) Rufus	(Last) Brown	4. DATE OF DEATH	(Month) June	(Day) 27	(Year) 195
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 10/21/1881	9. AGE last birthday 69 yrs.	If under Months	1 year Days	If under 24 hrs Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY W.M. Railroad	11. BIRTHPLACE (State or foreign country) Highfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Thomas Brown				14. MOTHER'S MAIDEN NAME Cynthia Wantz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 184-07-3834		17. INFORMANT AND ADDRESS Mrs. W.R. Brown, Highfield, Md.			

MARGIN RESERVED FOR BINDING

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <i>Chronic myocarditis</i>				
163X Antecedent cause(s)		(b) <i>Carcinoma left lung</i>				
47d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m. Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>6-27</u> , 19 <u>57</u> , to <u>6-30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-26</u> , 19 <u>57</u> , and that death occurred at <u>6-30</u> m., from the causes and on the date stated above. SIGNATURE <u>Harvey C. Bridges</u> (Degree or title) <u>Blue Ridge Limned</u> ADDRESS <u>Hanover</u> DATE SIGNED <u>6-29-57</u>						
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>6/29/1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Mt. Olivet</u>	LOCATION (City, town, or county) <u>Hanover</u>	(State) <u>Pa.</u>	
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Geo. W. Ferguson</u>		24 FUNERAL DIRECTOR <u>Halte G. Scott, Daynesboro, Pa.</u>		ADDRESS

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BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06334

## CERTIFICATE OF DEATH

Reg. Dist. No.

306

1. PLACE OF DEATH COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Cascade</u>		LENGTH OF STAY (in this place) <u>2 yrs. 3 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodbine</u>		STREET ADDRESS <u>RF D #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie Hospital</u>							
3. NAME OF DECEASED (Type or Print)	(First) <u>Muriel</u>	(Middle) <u>Lucinda</u>	(Last) <u>Conaway</u>	4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>5</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Aug 6 1887</u>	9. AGE last birthday	<u>63 yrs.</u>	If under Months	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Miller</u>	14. MOTHER'S MAIDEN NAME <u>Martha E. Brice</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS <u>Hospital Record</u>					

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Aspiration pneumonia INTERVAL BETWEEN  
ONSET AND DEATH  
2 weeks

Antecedent cause(s)

(b) Left hemiplegia 3 yrs 8 moDiseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(c) Cerebral thrombosis, recurrent 3 yrs. 8 mo

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerosis, General yrs.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  Yes  No

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY	m.				

22. I hereby certify that I attended the deceased from Sept. 1, 1949, to June 5, 1951, that I last saw the deceased alive on June 5, 1951, and that death occurred at 4:35 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL. (Specify) <u>Burial</u>	DATE <u>June 8, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Bethel Church of God Cemetery</u>	LOCATION (City, town, or county) <u>Carroll</u>	(State) <u>Ind</u>
DATE REC'D BY LOCAL REG. <u>6/15/51</u>	REG. <u>John O' Corcoran</u>	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR <u>C. M. Wally, Winfield, Ind.</u>	ADDRESS

REFUGEE

BUREAU U.S.

JUN 8 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06335

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH COUNTY Washington County MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Williamsport Maryland RFD #2		
TOWN Conococheague Md.			STREET ADDRESS (If rural, give location) Williamsport Md. RFD #2		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Gateway Convalescent Home					
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Wesley	(Last) Corby	4. DATE OF DEATH June	(Month) (Day) (Year) June 5 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH June 13 1865	9. AGE last birthday 95 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Finisher		10b. KIND OF BUSINESS OR INDUSTRY Tannery	11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME George Corby			14. MOTHER'S MAIDEN NAME Helen V. Kershner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 119-05-2172	17. INFORMANT AND ADDRESS Williamsport Md. Mr. Clarence H. Straley RFD #2		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Myocarditis Purpurea

INTERVAL BETWEEN  
ONSET AND DEATH

4 years

422.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b) Enteric septicemia

4 years

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year) m.	(Hour) White at Work <input type="checkbox"/> At work <input type="checkbox"/>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1947, 19, to June 5, 1951, that I last saw the deceased

alive on June 4, 1951, and that death occurred at 1 A.m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED  
6/6/51

23. BURIAL, Cremation REMOVAL (Specify) Burial	DATE THEREOF June 7 1951	NAME OF CEMETERY OR CREMATORIAL VIEW CEMETERY	LOCATION (City, town, or county) Williamsport Md.
DATE REC'D BY LOCAL REG. June 7 1951	REGISTRAR'S SIGNATURE C. Lee McElroy	24. FUNERAL DIRECTOR Albert L. Leaf	ADDRESS Williamsport Md.

RECEIVED

JUN 12 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY WASHINGTON			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY WASHINGTON		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN HAGERSTOWN			LENGTH OF STAY (in this place) 55		
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL			STREET ADDRESS 863 DEWEY AVE. (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) MITCHELL	(Middle) ANDREW	(Last) CORNWELL	4. DATE OF DEATH	(Month) JUNE (Day) 8 (Year) 1951
5. SEX	6. COLOR OR RACE MALE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 5/13/1894	9. AGE last birthday 57 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done, giving name of employer if possible)			10b. KIND OF BUSINESS OR INDUSTRY IRON WORKS	11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME WILLIAM CORNWELL, William			14. MOTHER'S MAIDEN NAME EMMA GARDNER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, NO known) If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 214-09-4884	17. INFORMANT AND ADDRESS MRS. STELLA M. CORNWELL HAG. MD.	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

3 hrs.

## Immediate cause

(a) Cerebral hemorrhage

## Antecedent cause(s)

(b) Hypertension.

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

None

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year)	(Hour) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 5, 1951, to June 8, 1951, that I last saw the deceased

alive on June 8, 1951, and that death occurred at 3:40 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

DATE SIGNED

M.D. Hagerstown, Maryland June 9, 1951.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 6/11/51	NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Md.	(State)
DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE Preston Bowers	24. FUNERAL DIRECTOR W. J. Norment	ADDRESS Hagerstown, Md.

RECEIVED

JUN 12 1951

BUREAU U. S.

06336

Dr. Hocklander

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH

COUNTY Washington

MARYLAND

CITY (if outside corporate limits, write RURAL and  
OR give nearest town)

TOWN Hagerstown

LENGTH OF STAY  
(in this place)  
6 DaysHOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS Washington Co. Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

WASHINGTIN

CITY (if outside corporate limits, write RURAL and give nearest town)

TOWN Hagerstown,

STREET (If rural, give location)

ADDRESS 109 South Mulberry Street

## 3. NAME OF

(First)

(Middle)

(Last)

(Type or Print)

Lela

Edna

Cromer

4. DATE (Month) (Day) (Year)

June 9, 1951

## 5. SEX

White

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify) Widowed

8. DATE OF BIRTH

April 18, 1884

67 yrs.

9. AGE last birthday  
If under 1 year  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR  
INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country)

Funkstown, Md.

12. CITIZEN OF WHAT  
COUNTRY U.S.A.

## 13. FATHER'S NAME

William Winfield Harbaugh

## 14. MOTHER'S MAIDEN NAME

Ida F. Warner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of  
service) no

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

John E. Harbaugh

## 18. MEDICAL CERTIFICATION

Sharpsburg Pike  
Hagerstown, Md.INTERVAL BETWEEN  
ONSET AND DEATH

5 days

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) P. O. Sideritis Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) Hypertension arterio sclerotic disease

P

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

Diabetes mellitus

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

(STATE)

## 21. ACCIDENT (Specify)

SUICIDE  
HOMICIDEPLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

## TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED

While at Work  At work 

HOW DID INJURY OCCUR?

m.

1951

a.m.

1951

p.m.

1951

BUREAU U. S.

JUN 13 1951

RECEIVED

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06337

Reg. Dist. No. 303

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) Clear Spring 2 weeks			CITY (If outside corporate limits, write RURAL and give nearest town) OR Hagerstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Near Ernsville			STREET (If rural, give location) ADDRESS Washington County Home		
3. NAME OF DECEASED (Type or Print)	(First) Lewis	(Middle) Ellsworth	(Last) Curley	4. DATE OF DEATH June 2	(Month) (Day) (Year) 1957
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH 10/2/1883	9. AGE last birthday 67	If under 1 year Months Days Hours Years
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY General Work	11. BIRTHPLACE (State or foreign country) Wash. Co., Md.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 220-10-3632	17. INFORMANT Information from acquaintances	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Acute alcoholic narcosis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? Had been on two weeks alcoholic binge		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

## SIGNATURE

*S. Robert Wells MD* DEPUTY MEDICAL EXAMINER 1153 Patowmac DATE SIGNED  
WASH. CO., MD. Hagerstown Md. 6-4-51

23. BURIAL, CREMATION REMOVAL, ETC.	DATE THEREOF 6/6/51	NAME OF CEMETERY OR CREMATORIUM Bellevue Cemetery	LOCATION (City, town, or county) Hagerstown	(State) Md.
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DATE REC'D BY LOCAL REG.	REG. NUMBER	REGISTRAR'S SIGNATURE J.W. Murray	24. FUNERAL DIRECTOR A.H. Rowland	ADDRESS Clear Spring, Md.
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RECEIVED

JUN 12 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06338

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH. COUNTY Washington			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Co. Hospital			STREET ADDRESS 34 N. Locust (If rural, give location)		
3. NAME OF DECEASED (Type or Print) Harry		(First) (Middle) L	(Last) Daley		4. DATE OF DEATH June 22
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11-15-1882	9. AGE last birthday 68 yrs.	If under 1 year Months Days Hours 19
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) york Foreman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Oscar Daley		14. MOTHER'S MAIDEN NAME Mary Stouffer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-4115	17. INFORMANT AND ADDRESS Mrs. H.L. Daley, 34 N. Locust City		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) *Hypertension - Pennsylvania*

6 days

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last(b) *Arterio-sclerosis - Genf*

1 year

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? Not While At work <input type="checkbox"/>
m.					

22. I hereby certify that I attended the deceased from June 16, 1951, to June 22, 1951, that I last saw the deceased alive on June 22, 1951, and that death occurred at 11:20 A.M., from the causes and on the date stated above.  
 SIGNATURE *A. A. Clegg* ADDRESS *145 W. Washington St Hagerstown Md.* DATE SIGNED *6/21/51*

23. BURIAL, CREMATION REMOVED (Specify)	DATE THEREOF June 25, 1951	NAME OF CEMETERY OR CREMATORIAL Rest Haven	LOCATION (City, town, or county) Hagerstown	(State) Md.
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DATE REC'D BY LOCAL REG. <i>June 25, 1951</i>	REGISTRAR'S SIGNATURE <i>Bethel Powers</i>	24. FUNERAL DIRECTOR Fred W. Kraiss	ADDRESS
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RECEIVED  
BUREAU V. S.

JUN 27 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06339

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural P.D. 4.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington Co. Hosp.				STREET ADDRESS (If rural, give location) Maysville Rd.	
3. NAME OF DECEASED (First) MICHAEL (Middle) Edward Dafflemeyer		(Last)		4. DATE OF DEATH June 19 1951	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH June 19, 1951	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		9. AGE last birthday If under 1 year Months Days Hours Min. yrs.	
13. FATHER'S NAME Warren Edward Dafflemeyer		14. MOTHER'S MAIDEN NAME Olyslies Glene Morris		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.	
17. INFORMANT Mrs. Warren E. Dafflemeyer					

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
773.5 Immediate cause		(a) Respiratory failure - central origin		3 <sup>36</sup>
159 Antecedent cause(s)		(b) Prematurity - 30 wk preg.		
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) None		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work At work		DATE (CITY OR TOWN) (COUNTY) (STATE)

22. I hereby certify that I attended the deceased 6-18-51, 19..., to ..., 19..., that I last saw the deceased alive on 6-18, 1951, and that death occurred at 5:35 p.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE		NAME OF CEMETERY OR CREMATORIAL REG.		LOCATION (City, town, or county) (State)	
Burial June 20, 1951 Post Hager Cemetery		Post Hager Cemetery		Hagerstown, Md. 6-18-57	
DATE REC'D. BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
June 20, 1951 Post Hager Cemetery		Post Hager Cemetery		Post Hager Funeral Chapel Hagerstown, Md.	
				206191262 321	

MARGIN RESERVED FOR BINDING

correct age

careful

of information carefully

Supply every item of information carefully

especially important. Physicians: please write the causes of death clearly and legibly

BUREAU V. S.

JUN 22 1951

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06340

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH. COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE		COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		STREET ADDRESS		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cascade 7 months		Davidsonville.		(If rural, give location)		
3. NAME OF DECEASED (Type or Print)		(First) Eugene	(Middle) Sampson	(Last) Done	4. DATE OF DEATH	(Month) June	(Day) 3	(Year) 1951
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under Months	1 year Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		Mar. 17, 1888	63 yrs.			
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)		Maryland		12. CITIZEN OF WHAT COUNTRY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME		U.S.A.		
17. INFORMANT AND ADDRESS		Hospital Record						

MARGIN RESERVED FOR BINDING

18. MEDICAL CERTIFICATION								
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
Immediate cause		(a) Encephalomalacia						
332X Antecedent cause(s)		(b) Generalized arterio-sclerosis						
30d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) Syphilitic Aneurysm of Ascending Aorta						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Nov. 3, 1950, to June 3, 1951, that I last saw the deceased alive on June 3, 1951, and that death occurred at 6:15 P.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, Cremation (Remove)		DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
DATE LEGGED BY LOCAL REG.		REGISTERER'S SIGNATURE		(Date)
4/4/51		M. J. Clayton		24. FUNERAL DIRECTOR
				ADDRESS
				V. A. Hoadley & Son, Galveston
				WV W. Md.

THE CORRECT AGE

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED

M 16 1951

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06341

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Williamsport Md		LENGTH OF STAY (in this place) 46 Yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 E Potomac Street		STREET ADDRESS 23 E Potomac Street (If rural, give location)	
3. NAME OF DECEASED (Type or Print) Newton	(First) Kurtz	(Last) Downs	4. DATE OF DEATH June 3 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH April 13 1866 85 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Messenger		10b. KIND OF BUSINESS OR INDUSTRY U.S. Postal Ser	
11. BIRTHPLACE (State or foreign country) Downsville Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher Downs		14. MOTHER'S MAIDEN NAME Anna Rebecca Curfman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Williamsport Md.		Norris Downs 25 E Potomac Street	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Myocarditis Chronic Antecedent cause(s) (b) Rheumatic heart disease Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
INTERVAL BETWEEN ONSET AND DEATH 48 hours			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1, 1951, to June 3, 1951, that I last saw the deceased alive on June 3, 1951, and that death occurred at 4 A. m. from the causes and on the date stated above. SIGNATURE: <i>John B. Curfman</i> ADDRESS: <i>Williamsport</i> DATE SIGNED: <i>6/4/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 5 1951	
DATE REC'D BY LOCAL REG. June 5 1951		NAME OF CEMETERY OR CREMATORIUM Riverview Cemetery	
REG. No. Lee McElroy		LOCATION (City, town, or county) (State) Williamsport Maryland	
REG. No. Lee McElroy		24. FUNERAL DIRECTOR Williamsport Md ADDRESS Albert L Leaf #7 Church Street	

BUREAU V. S.

JUN 7 1951

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06342

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Washington MARYLAND		Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Pen Mar		TOWN Baltimore	
LENGTH OF STAY (in this place)		STREET (If rural, give location)	
20 days.		ADDRESS 355 Yale Ave	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Katherine		(Month) (Day) (Year)	
(Middle)		JUN 28 1951	
(Last) Doxie			
5. SEX Female		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH May 22 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		9. AGE last birthday 68 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME James F. Doxie		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mrs Frank J. Dotterwich, Balt. Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause 420.1		(a) Coronary Occlusion 1/2 hour	
Antecedent cause(s) 93d		(b) Arteriosclerosis Cardio Vasculare Unknown	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 28 Jun., 1951, to 28 Jun., 1951, that I last saw the deceased alive on 28 Jun., 1951, and that death occurred at 6:30 A.M., from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS	
DATE SIGNED					

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 6/30/1951		NAME OF CEMETERY OR CREMATORIUM New Cathedral		LOCATION (City, town, or county) Baltimore		(State) Md.	
DATE REC'D BY LOCAL REG. 6-30-51		REGISTRAR'S SIGNATURE Dr Joseph W Murray Esq. Farley		24. FUNERAL DIRECTOR ADDRESS Baltimore, Md.					



06343

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr Cohen

## CERTIFICATE OF DEATH

Reg. Dist. No. 801

1. PLACE OF DEATH COUNTY <b>Washington</b>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Washington</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Williamsport</b>		LENGTH OF STAY (in this place) <b>10 yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Williamsport</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 44 west Salisbury St.		STREET ADDRESS <b>44 West Salisbury St.</b>	(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>ELSIE</b>	(Middle) <b>ALMEDA</b>	(Last) <b>DURBORAW</b>	4. DATE OF DEATH <b>June 10 1951</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Mar 9 1885</b>	9. AGE last birthday <b>66</b> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md</b>	12. COUNTRY OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Daniel Rice</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Potts</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Year, no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT AND ADDRESS <b>William T. Durboraw</b>	
18. MEDICAL CERTIFICATION <b>Williamsport Md.</b>				

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause

(a) **Adeno carcinoma stomach**INTERVAL BETWEEN  
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) **as Fibroic Sarcoma - Rt femur****duration -  
unknown -  
unknown -**

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.**Chronic auricular fibrillation -****Unknown -**

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

**none -****none****20. AUTOPSY?****Yes  No** 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
**INJURY**

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at  
m. Work  At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **May 22, 1951**, to **June 10, 1951**, that I last saw the deceasedalive on **June 10, 1951**, and that death occurred at **10:15 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Alice Cohen****m.o.****Clear Spring Md.****6-11-51**23. BURIAL, CREMATION  
REMOVAL (Specify)**Burial**

DATE THEREOF

**6/12/51**

NAME OF CEMETERY OR CREMATORIAL

**Rose Hill Cemetery**

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL  
REG.**6/11/51**

REGISTRAR'S SIGNATURE

**E Lee McElroy**

24. FUNERAL DIRECTOR

**Andrew K. Coffman Hagerstown Md.**

RECEIVED

JUN 15 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06344

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH. CITY OR TOWN		Washington Cascade Md.		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE CITY OR TOWN		Md.		COUNTY Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Cascade Md.				STREET ADDRESS		Cascade Md.		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First) Charles	(Middle) E.	(Last) Flaughher			4. DATE OF DEATH	(Month) June	(Day) 1	(Year) 1951	
5. SEX m		6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) w.	8. DATE OF BIRTH Nov. 16, 1868	9. AGE last birthday 82 yrs.		10. KIND OF BUSINESS OR INDUSTRY Blacksmith	11. BIRTHPLACE (State or foreign country) Cascade Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b.		11.		12.					
13. FATHER'S NAME William Flaughher				14. MOTHER'S MAIDEN NAME Caroline Nicholas							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sylvia Wastler, Cascade Md.		18. MEDICAL CERTIFICATION Carriara A & Clusion		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  1120.1 Immediate cause (a) Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last 94a (c)											
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE TIME OF INJURY		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY				(CITY OR TOWN)		(COUNTY)			
(Day) (Year) (Hour)		INJURY OCCURRED While at Work m. Not While At work				HOW DID INJURY OCCUR?		(STATE)			
22. I hereby certify that I attended the deceased from 10-10, 1940 to 5-31, 1951 that I last saw the deceased alive on 5-31, 1951, and that death occurred 5-31, 1951, from the causes and on the date stated above. Degree of title SIGNATURE Harvey B. Craggs ADDRESS Blue Ridge Cemetery DATE SIGNED 5-31-51											
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6/3/51		NAME OF CEMETERY OR CREMATORIAL Bethel C.		LOCATION (City, town, or county) Cascade Washington Md.		(State)			
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE Geo. W. Freeman		24. FUNERAL DIRECTOR Walter J. Grove		ADDRESS Waynesboro Pa.					

RECEIVED  
JUN 4 1968  
BUREAU V-5

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06345

307

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH Washington			2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND Maryland				
CITY (If outside corporate limits, write RURAL and OR give nearest town)			CITY (If outside corporate limits, write RURAL and give nearest town)				
TOWN Williamsport			TOWN Hagerstown				
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)				
Williamsport Nursing Home			131 S. Prospect St.				
3. NAME OF DECEASED (Type or Print)	(First) REBECCA	(Middle) HOLLINGSWORTH	(Last) FRENCH	4. DATE OF DEATH	(Month) June	(Day) 7	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.	
Female	White	Single	Oct 2 1861	89	Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			
Housework			Own Home	Hagerstown, Md.			
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			12. CITIZEN OF WHAT COUNTRY	
George French			Elizabeth R. Hollingsworth			USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS			
(If yes, give war or dates of service)			None	Mrs Kate Dawson Hagerstown Md			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Chronic Endocarditis - Myocarditis

INTERVAL BETWEEN  
ONSET AND DEATH

10 yrs.

4214 Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) Rheumatic Endocarditis

20 yrs

92d

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
		INJURY			

TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED  
OF  
INJURY m. While at Not While  
Work  At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 204x5, 19....., to ..... 19....., that I last saw the deceased  
alive on May 31, 1951, and that death occurred at ..... m., from the causes and on the date stated above.  
SIGNATURE H. G. Green Help ADDRESS 145 W. Washington St. Hagerstown Md. DATE SIGNED May 31 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)
Burial	6-11-51	Rose Hill Cemetery	Hagerstown, Md.
DATE RECD BY LOCAL REG.	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
6/11/51	C. Lee McElroy	Andrew K. Coffman	Hagerstown, Md.

RECEIVED  
BUREAU U. S.

JUN 4 1951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06346

Dr Hirshman  
Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b> Maryland</b>		COUNTY <b>Washington</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Hagerstown</b>		LENGTH OF STAY (in this place) <b>24 Hrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>		(If rural, give location) STREET ADDRESS <b>113 W. Howard St.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wash. County Hospital</b>							
3. NAME OF DECEASED (Type or Print) <b>WILLIAM WESTFALL</b>		(First) (Middle) (Last) <b>GARRETT</b>		4. DATE OF DEATH <b>June 19 51</b>		(Month) (Year)	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>12/20/1889</b>	9. AGE last birthday <b>61 yrs.</b>	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Needmore, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>George Garrett</b>		14. MOTHER'S MAIDEN NAME <b>Jane Bean</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>315-28-2215</b>		17. INFORMANT AND ADDRESS <b>Charles Garrett Hagerstown Md.</b>		370 S. Cannon Ave	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <b>Coronary Occlusion</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Arteriosclerosis - Deceased</b>						<b>years</b>	
440a		(a) _____ (b) _____ (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?				
OF INJURY m.							
22. I hereby certify that I attended the deceased from <b>June 23, 1951</b> to <b>June 26, 1951</b> , that I last saw the deceased alive on <b>June 25, 1951</b> , and that death occurred at <b>7 p.m.</b> from the causes and on the date stated above.							
SIGNATURE <b>July 1 McLean</b>		(Degree or title) <b>MD</b>		ADDRESS <b>Hagerstown Md</b>		DATE SIGNED <b>6/25/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6/29/51</b>		NAME OF CEMETERY OR CREMATORIAL <b>Rest Haven Cemetery</b>		LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
DATE REC'D BY LOCAL REG. <b>June 26, 1951</b>		REGISTRAR'S SIGNATURE <b>Ghost Boward</b>		24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	

RECEIVED  
JUN 28 1951

BUREAU Y. S.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06347

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <b>Washington</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Hagerstown</b>		LENGTH OF STAY (in this place) <b>1 day</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wash. County Hospital</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Rural-Sharsburg</b>	
3. NAME OF DECEASED (First) <b>Frisby</b> (Middle) <b>Tilden</b> (Type or Print)		4. DATE OF DEATH <b>June 10 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 18, 1886</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner grocery store</b>		9. AGE last birthday <b>65 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Antietam-Wash.-Maryland</b>	
13. FATHER'S NAME <b>George Gray</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-1278</b>	
17. INFORMANT AND ADDRESS <b>Mrs. Mary Gray--Rural Sharpsburg, Md</b>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) **Acute coronary thrombosis**  
**arteriosclerotic heart disease**

INTERVAL BETWEEN  
ONSET AND DEATH**4 days**  
**5 Yrs?**

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause inst

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) m.	(Year) h.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **6/1/51**, 19....., to **6/10/51**, 19....., that I last saw the deceased  
alive on **6/10/51**, 19....., and that death occurred at **10:35** m., from the causes and on the date stated above.

SIGNATURE

M. D.

ADDRESS

DATE SIGNED

**Sharpsburg, Md. June 11, 1951.**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>6/13/51</b>	NAME OF CEMETERY OR CREMATORIAL <b>Mt. View</b>	LOCATION (City, town, or county) <b>Sharpsburg, Md.</b>	(State)
DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE <b>Franklin J. Frisby</b>	24. FUNERAL DIRECTOR <b>R. I. Earnshaw--Keedysville, Md.</b>		

VS. A/B

632636

RECEIVED

MAR 18 1951

BUREAU A. S.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06348

Reg. Dist. No. 302

1. PLACE OF DEATH CITY <b>Washington D.C.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Virginia</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Hagerstown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Lovettsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS & EAST BALTIMORE ST		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) <b>Edna Pauline Green</b>		4. DATE OF DEATH <b>June 28 1951</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>13 March 1916</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W. Va.</b>	12. CITIZEN OR WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Paul Howard Barbehenn</b>		14. MOTHER'S MAIDEN NAME <b>Mary Josephine Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Miss Vera Barbehenn</b>	
18. MEDICAL CERTIFICATION <b>Martinsburg W. Va.</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
819.5 Immediate cause <b>Fractured skull</b>	(a)	INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Haemorrhage</b>	(b)		
170c <b>Haemorrhage</b>	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. <b>Injury</b>	PLACE (Home, farm, factory, street, office bldg., etc.) <b>E. Baltimore St. Hagerstown, Md.</b>	(CITY OR TOWN) (COUNTY) (STATE) <b>E. Baltimore St. Hagerstown, Md.</b>	
TIME (Month) (Day) (Year) OF INJURY <b>6. 28. 51</b>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> <b>4:30 p.m.</b>	HOW DID INJURY OCCUR? <b>Auto Collision</b>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>S. Robert Kelly MD</b>	(Degree or title) <b>DEPUTY MEDICAL EXAM.</b>	DATE SIGNED <b>6. 28. 51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>7/2/51</b>	NAME OF CEMETERY OR CREMATORIUM <b>Evergreen Cemetery</b>	LOCATION (City, town, or county) (State) <b>Gettysburg Adams Pa.</b>
DATE REC'D BY LOCAL REG. <b>June 30, 1951</b>	REG. <b>B. Ross Bowers</b>	24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>	ADDRESS <b>Hagerstown, Md.</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06349

## CERTIFICATE OF DEATH

Reg. Dist. No. 3510

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Washington MARYLAND		Md. COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First) Christian (Middle) G (Last) Grotz	4. DATE OF DEATH June 16 1951
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) M.	8. DATE OF BIRTH June 7, 1871 80
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farm labor	9. AGE last birthday If under 1 year Months Days Hours yrs. 11. BIRTHPLACE (State or foreign country) Germany
13. FATHER'S NAME Johannes Grotz		14. MOTHER'S MAIDEN NAME Louisa Schray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Elizabeth Grotz, Edgemont Md.	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

2 months

## 332 X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

831

(b) Hypertension &amp; Atherosclerosis

years.

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED White at Work	HOW DID INJURY OCCUR? Not White At work
m.					

22. I hereby certify that I attended the deceased from Oct., 1950, to 16 June, 1951, that I last saw the deceased

alive on 16 June, 1951, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

John Dean Wilson M.D.

Smithsburg, Md.

6/18/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	6/18/51	Smithsburg	Smithsburg	Washington

DATE REC'D BY LOCAL REG.	REG. NO.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 18-51	100-14	Ferguson	Walter G. Grove	Waynesboro Pa.

820105

RECEIVED

BUREAU V. S.

MAR 21 1952



RECEIVED

JUN 14 1951

BUREAU U. S.



BUREAU V. S.

JUN 13 1951

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06352

## CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Keedysville			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keedysville		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS Main		
3. NAME OF DECEASED (Type or Print) John Henry Hammond			4. DATE OF DEATH June 30 1951		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH 11-29-1873	9. AGE last birthday 77	If under 1 year yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor			10b. KIND OF BUSINESS OR INDUSTRY School		
13. FATHER'S NAME William K. Hammond			11. BIRTHPLACE (State or foreign country) Downsville, Md		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			12. CITIZEN OF WHAT COUNTRY? U. S.		
16. SOCIAL SECURITY NO. None			17. INFORMANT AND ADDRESS Mrs Mary Long--Keedysville, Md		

## 18. MEDICAL CERTIFICATION

MARGIN RESERVED FOR BINDING

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause (a) Pernicious Anemia

7 Mo. 12Da

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b) Gastric Ulcer

" "

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) m.	(Year) h.	INJURY OCCURRED While at Work <input type="checkbox"/>	Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 18, 1950, to June 30, 1951, that I last saw the deceased alive on June 30, 1951, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

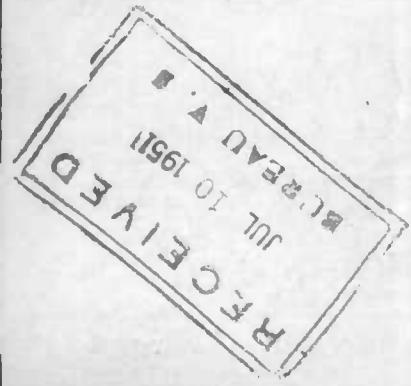
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF July 3, 1951	NAME OF CEMETERY OR CREMATORIAL Lutheran	LOCATION (City, town, or county) Bakersville, Md	(State)
DATE REC'D BY LOCAL REG. July 3, 1951	REGISTRAR'S SIGNATURE R. H. Hartung	24. FUNERAL DIRECTOR R. I. Earnshaw--Keedysville, Md		

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

06353

Dr Wells

Reg. Dist. No. 302

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

1. PLACE OF DEATH: <b>Washington</b>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: <b>Maryland Washington</b>		COUNTY <b>Washington</b>
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wash. County Hospital</b>		STREET ADDRESS <b>412 West Washington St.</b>			
3. NAME OF DECEASED (Type or Print)	(First) <b>SAMANTHA</b>	(Middle) <b>CEARFOSS</b>	(Last) <b>HARNE</b>	4. DATE OF DEATH <b>June 29 1951</b>	(Month) (Day) (Year)
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. <b>Married</b>	8. DATE OF BIRTH <b>Aug 20 1905</b>	9. AGE last birthday <b>45</b>	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer- Caskey Baking Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co. Md. U.S.</b>	12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>Lucius Cearfooss</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Bonebrake</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-2148</b>	17. INFORMANT AND ADDRESS <b>William E. Harne</b>		
18. MEDICAL CERTIFICATION <b>412 W. Wash. St.</b>					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p><b>420.0</b>          Immediate cause      (a) <i>Anterior-sclerotic coronary heart disease</i>          Antecedent cause(s)      (b) <i>Acute coronary occlusion</i>          Diseases or conditions, if any, giving rise to the above cause          stating the underlying cause last      (c) <i></i></p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <b>None</b>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <b>Dropped dead at work</b>		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>					
SIGNATURE <b>S. Robert Wells M.D.</b>		DEPUTY OF MEDICAL EXAMINER <b>115 N. Patomac St.</b>	DATE SIGNED <b>Hagerstown, Md. 6/29/51</b>		
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>7-1-51</b>	NAME OF CEMETERY OR CREMATORIUM <b>Rose Hill Cemetery</b>	LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>		
DATE REC'D BY LOCAL REG. <b>June 30, 1951</b>	REGISTRAR'S SIGNATURE <b>Leah Bowers</b>	24. FUNERAL DIRECTOR ADDRESS <b>Andrew K. Coffman Hagerstown Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06354

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY		Washingto MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Maryland COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS		
TOWN Boonsboro		19 months		Meyersville		(If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS								
3. NAME OF DECEASED (Type or Print)		(First) Charles	(Middle) Ezra	(Last) Harshman	4. DATE OF DEATH	(Month) June	(Day) 15	(Year) 1951
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
Male		White	Marry	Feb 28-1876	75	yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY		
Farmer		Farms		Lodging Farming		Md. Maryland		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Samuel Harshman		Barbara Fannie Welf						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS				
		None		Mrs. Lesta Harshman, Boonsboro Md.				

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Cardio-Renal - Vascular disease

6 yrs

442X

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

131a

(b)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
INJURY		TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from ..... , 1944, to June 15, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 12:30 A.M., from the causes and on the date stated above.  
 SIGNATURE E. Harp M.D. ADDRESS Middleton DATE SIGNED June 15-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
DATE REC'D BY LOCAL REG.	REG.	John H. Baal	Paul F. Bittle, Meyersville	Frederick Co. Md.
REG.	REG.			

RECEIVED

JUN 22 1951

BUREAU U. S.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06355

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Hagerstown (In this place) 12 yrs.			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown STREET ADDRESS 59 W. Bethel St. (If rural, give location)		
HOSPITAL OR INSTITUTION OR 59 W. Bethel St. STREET ADDRESS					
3. NAME OF DECEASED (First) George (Middle) Romeo (Last) Herbert		4. DATE OF DEATH 6 4 1951			
5. SEX Male COLOR OR RACE Negro		6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		7. DATE OF BIRTH 8/5/1891 9. AGE last birthday 59 If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Bricklayer		
11. BIRTHPLACE (State or foreign country) Sharpsburg, Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME David Hervert			14. MOTHER'S MAIDEN NAME Fannie Gray		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Pearl Jones 59 W. Bethel St.	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

420.0 Antecedent cause(s) (a) Arteriosclerotic coronary heart  
disease  
93d Disease or conditions, if any, (b) ...  
giving rise to the above cause  
stating the underlying cause last  
(c) Acute coronary occlusion

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION None			20. AUTOPSY?
			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> <input type="checkbox"/> at work	HOW DID INJURY OCCUR? Note: Fell over dead on porch		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

## SIGNATURE

Robert Wells, M.D.

## (DEPUTY) MEDICAL EXAMINER

115 N. Potomac St.  
Hagerstown, Md.DATE SIGNED  
6/6/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-7-51	NAME OF CEMETERY OR CREMATORIAL NATIONAL Cemetery	LOCATION (City, town, or county) Sharpsburg, Md.	(State)
---	------------------------	--	---	---------

DATE REC'D BY LOCAL REG. June 7, 1951	REGISTRAR'S SIGNATURE B. Kastell Powers	24. FUNERAL DIRECTOR John R. Watson Jr. 59 W. Bethel St. Hagerstown, Md.	ADDRESS 911 1/16
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RECEIVED

JUN 11 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

06356

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
WASHINGTON MARYLAND		MARYLAND COUNTY WASHINGTON	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN ROHRSVILLE		TOWN ROHRSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MAIN ST.		STREET ADDRESS MAIN ST.	
3. NAME OF DECEASED (First) GRACE (Middle) ELIZABETH (Last) HOVERMALE		4. DATE OF DEATH JUNE - 22 - 1951	
5. SEX FEMALE WHITE		6. COLOR OR RACE	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) MARRIED		8. DATE OF BIRTH MAY-30-1900	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		9. AGE last birthday 51 - 0 - 22 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) ROHRSVILLE WASH. Co., MD.	
13. FATHER'S NAME SAMUEL J. MULLENDORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT AND ADDRESS WM. H. HOVERMALE ROHRSVILLE MD.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Acute Pulmonary Edema. Sudden			
Antecedent cause(s) (b) Rheumatic Heart Disease with Auricular fibrillation Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Mitral Stenosis. lMo.19da.			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
OF INJURY m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 3, 1951, to June 22, 1951, that I last saw the deceased alive on June 14, 1951, and that death occurred at 10.10 A.M., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
John E. Dagenhardt		m. a. Boonsboro, Md. 6/25/51	
23. BURIAL, CREMATION REMOVAL (Specify) ENCRYPTION		DATE THEREOF JUNE-25-1951 NAME OF CEMETERY OR CREMATORIAL MAUSOLEUM LOCATION (City, town, or county) Boonsboro WASH. Co. MD. (State)	
DATE REC'D BY LOCAL REG. REC.		REG. REC. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
Jane 25-1951 Katherine Dagenhardt W.M. E. BAST AND SONS Boonsboro MD.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415 T



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06357

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hagerstown</u>	
LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hagerstown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>341 N Jonathans St.</u>		STREET ADDRESS <u>341 N Jonathans St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Robert</u>	(First)	(Middle) <u>Edwin</u>	(Last) <u>Jackson</u>
4. DATE OF DEATH <u>6 27 1951</u>	(Month)	(Day)	(Year)
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>5-29-1910</u>
9. AGE last birthday <u>41 yrs.</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Furniture, Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>153 W North St.</u>
13. FATHER'S NAME <u>Robert Sherman Jackson</u>	14. MOTHER'S MAIDEN NAME <u>Edna Virginia King</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>118</u>	17. INFORMANT AND ADDRESS <u>Mrs. Edna V. Jackson, Hagerstown, Md.</u>	18. MEDICAL CERTIFICATION <u>Pulmonary Tuberculosis - 4 years</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  0024 Immediate cause (a) _____ Antecedent cause(s) _____ Diseases or conditions, if any, (b) _____ giving rise to the above cause stating the underlying cause last 13b _____ (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> m.	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 27, 1951</u> , to <u>June 27, 1951</u> , that I last saw the deceased alive on <u>June 27, 1951</u> , and that death occurred at <u>9 A.M.</u> m., from the causes and on the date stated above. SIGNATURE <u>Philip Johnson</u> ADDRESS <u>Hagerstown Md.</u> DATE SIGNED <u>6/29/57</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6-30-1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Tolson Chapel</u>	LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland</u>
DATE REC'D BY LOCAL REG. <u>June 30, 1951</u>	REGISTRAR'S SIGNATURE <u>Robert Powers</u>	24. FUNERAL DIRECTOR ADDRESS <u>John R. Watson Jr. Hagerstown Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06358

Reg. Dist. No.

302

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1020 Corbett St.			STREET ADDRESS (If rural, give location) 1020 Corbett St.,		
3. NAME OF DECEASED (Type or Print)	(First) Ida	(Middle) Mae	(Last) Jacobs	4. DATE OF DEATH	(Month) 6 (Day) 24 (Year) 51 <sub>19</sub>
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-24-1888	9. AGE last birthday 62 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Hancock, Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME MORTIS Snook			14. MOTHER'S MAIDEN NAME Sarah Ellen Mort		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Clayton Jacobs, 1020 Corbett St	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Coronary Occlusion 260X Antecedent cause(s) (b) Arterio sclerosis (generalized) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 61 (c) Diabetes Mellitus					
INTERVAL BETWEEN ONSET AND DEATH 1/2 hrs					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. N/A					
19a. DATE OF OPERATION W		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? m.	
22. I hereby certify that I attended the deceased from Oct 1936, to 24 Jun, 1951, that I last saw the deceased alive on 24 Jun, 1951, and that death occurred at 130 P.m., from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED E. L. Husky Jr. 25th June 27 Jun 1951					
23. BURIAL, CREMATION REMOVED (Specify)		DATE THEREOF 6-27-51		NAME OF CEMETERY OR CREMATORIAL Rest Haven	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE June 27, 1951		LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Fred A. Kraiss				ADDRESS	

RECEIVED

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JUN 28 1951

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4701m

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06359

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wash	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown LENGTH OF STAY TOWN 1 minute		CITY (If outside corporate limits, write RURAL and give nearest town) OR Hagerstown STREET (If rural, give location) TOWN ADDRESS 118 N. Locust	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Was. County Hospital			
3. NAME OF DECEASED (Type or Print)	(First) Gerald	(Middle) Donald	(Last) Kauffman Jr.
4. DATE OF DEATH	June	(Month) 8 (Day)	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH June 8, 1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Hagerstown Md.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Gerald D. Kauffman Sr.	14. MOTHER'S MAIDEN NAME Eleanor Hershey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. -----	17. INFORMANT AND ADDRESS Gerald D. Kauffman Sr. Hag. Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 760.0	(a) Respiratory failure, probably central and due to intracranial	INTERVAL BETWEEN ONSET AND DEATH 1-10 min	
Antecedent cause(s) 160a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hemorrhage	1-10 min	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Prolonged 2nd stage of labor 6 hrs.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, to _____, 19_____, that I last saw the deceased alive on 6-8-51, and that death occurred at 3:30 a.m., from the causes and on the date stated above.			
SIGNATURE Robert J. Keader	(Degree or title) MD	ADDRESS 132 W. Wash St. Hagerstown	DATE SIGNED 6-9-51
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF June 9, 1951	NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE John Powers	24. FUNERAL DIRECTOR Scott F. Minnich & Son	ADDRESS Hag. Md.

RECEIVED

JUN 12 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06360

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington			
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Hagerstown Md.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 10 N. Vermont Street			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		STREET (If rural, give location) ADDRESS Williamsport Maryland			
3. NAME OF DECEASED (Type or Print)	(First) Inez	(Middle) Frances	(Last) Kerns		
4. DATE OF DEATH	(Month) June	(Day) 5	(Year) 1951		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH		
Female	White		9. AGE last birthday Dec. 19 1892 58 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Park Head Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
Lewis Myers	Lucy Wiland				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. No	17. INFORMANT AND ADDRESS	10 N Vermont St. Md		
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <i>420.1</i>	(a) <i>Coronary Thrombosis</i>				
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>94a</i>	(b) _____				
(c) _____					
5 Days					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY?					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at m. Work	HOW DID INJURY OCCUR? Not While At work		
22. I hereby certify that I attended the deceased from 5/31/51 to 6/5/51, 19, that I last saw the deceased alive on 6/5/51, 19, and that death occurred at 9:30 P.m., from the causes and on the date stated above.				DATE SIGNED	
SIGNATURE	(Degree or title)			ADDRESS	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)	
Burial	June 8 1951	Greenlawn Cemetery	Williamsport Md.		
DATE REC'D BY LOCAL REG.	REGISTAR'S SIGNATURE	24. FUNERAL DIRECTOR			ADDRESS
June 8 1951	<i>Chasft Boersma</i>	Albert L. Leaf			Williamsport Md.
To Rec'd from Mrs. McAdory 6/12/51					

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JUN 14 1951

BUREAU U. S.

6-21-51 ams

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06361

Reg. Dist. No. 305

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Boonsboro</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>NORTH MAIN ST.</b>		LENGTH OF STAY (in this place) <b>LIFE</b>	
3. NAME OF DECEASED (First) <b>JOHN</b>		(Middle) <b>HUBERT</b>	
4. DATE OF DEATH <b>JUNE - 8 - 1951</b>		(Last) <b>KNODE</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>APRIL - 24 - 1868 - 83 - 1 - 14 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>REAL ESTATE OPERATOR - RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Boonsboro WASH. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL KNODE</b>		14. MOTHER'S MAIDEN NAME <b>KATHARINE LANE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT AND ADDRESS <b>MRS. KATHARINE KNODE BOONSBORO MD.</b>		18. MEDICAL CERTIFICATION <b>Lobes Tracheitis</b> <b>Tracheitis Belovaria</b> <b>Tracheal Diphtheritis</b>	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>108</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>3 yrs. 3 mos.</b> <b>11 0</b>	
20. AUTOPSY? <b>Yes <input type="checkbox"/> No <input type="checkbox"/></b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>(6-21-51 - ams)</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 12, 1948</b> , to <b>June 8, 1951</b> , that I last saw the deceased alive on <b>June 7, 1951</b> , and that death occurred at <b>1:30 A.M.</b> on the causes and on the date stated above. SIGNATURE <b>John H. Best</b>		ADDRESS <b>Boonsboro Md.</b> DATE SIGNED <b>6/9/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>JUNE - 9 - 1951</b>	
DATE REC'D BY LOCAL REG. REC.		NAME OF CEMETERY OR CREMATORIAL <b>Boonsboro CEMETERY</b>	
REG.		LOCATION (City, town, or county) <b>Boonsboro WASH. CO. MD.</b>	
		(State) <b>MD.</b>	
REG.		24. FUNERAL DIRECTOR <b>W.M. F. BAST AND SONS BOONSBORO MD.</b>	
		ADDRESS <b>470 7th</b>	

DR. WADDE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AJ5

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JUN 12 1951

BUREAU Y. S.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06362

Reg. Dist. No. 302

1. PLACE OF DEATH CITY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE West Virginia COUNTY Monongalia	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Near Buyetts Croos Roads Paasing thru		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morgantown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS On Highway		STREET ADDRESS (If rural, give location) 244 McLane Avenue	
3. NAME OF DECEASED (Type or Print)	(First) Ivy	(Middle) Blanche	(Last) Krouse
4. DATE OF DEATH June 24 1957	(Month)	(Day)	(Year)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 10-12-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 57 yrs.	If under 1 year Months Days Hours Min.
13. FATHER'S NAME Tom Hyland	11. BIRTHPLACE (State or foreign country) Smithton, Pa.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 235-52-1823	17. INFORMANT AND ADDRESS Evaline K. McCutcheon	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) 420.1 Antecedent cause(s) acute coronary occlusion			12 hrs
Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None	INJURY OCCURRED While at m. Not while work <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? Sudden death enroute to Hospital	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Robert Wells M.D.	(Degree or title) DEPUTY MEDICAL EXAM.	DATE SIGNED 6-24-57	
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 6-25-1951	NAME OF CEMETERY OR CREMATORIAL Davidson Bros. Fun. Home	LOCATION (City, town, or county) (State) Morgantown, W. Va.
DATE REC'D BY LOCAL REG.	REG. 6-24-1957	REGISTRAR'S SIGNATURE Thomas Flowers	24. FUNERAL DIRECTOR C. M. Suter & Sons, Hagerstown, Md.

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JUN 26 1951  
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## MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06363

Reg. Dist. No. 304

I. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE	
Washington MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) Eckhart Allegany Md.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hancock		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Robert (Middle) Cecil (Last) Lancaster		(Month) June (Day) 25 (Year) 1951	
5. SEX Male		6. COLOR OR RACE White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH March 7, 1900	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner		9. AGE last birthday 51 If under 1 year Months 6 Days 12 Hours 12 Min. 12	
10b. KIND OF BUSINESS OR INDUSTRY Coal miners		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John J. Lancaster		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-01-3753	
17. INFORMANT Mrs. Caroline Griffith (Baltimore Md.)		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
929.8 Immediate cause (a) asphyxia - by drowning			
183 Antecedent cause(s) (b) (c) asphyxia - by drowning			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) INJURY 6 15 51 m.		INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/> ? HOW DID INJURY OCCUR? Found in Potomac River	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE J. Robert Wells M.D., Deputy Med. Corp. Wash Co. Hagerstown, Md.		DATE SIGNED 6-25-51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6-29-51	
DATE REC'D BY LOCAL REG. 6-27-51		NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery	
REGISTRAR'S SIGNATURE J A Heller		LOCATION (City, town, or county) Echhart Allegany Md.	
		24. FUNERAL DIRECTOR Charles P. Bast	
		ADDRESS 650216	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06364

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Co. Hospital			STREET ADDRESS 104 Cypress St., (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) Joseph	(Middle) I	(Last) Lyon	4. DATE OF DEATH	(Month) 6 (Day) 27 (Year) 1951
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-25-1891	9. AGE last birthday 60 yrs.	If under 1 year Months Day Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CITY Engineer			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Penns.			12. CITIZEN OF WHAT COUNTRY U.S.		
13. FATHER'S NAME Jacob Lyon			14. MOTHER'S MAIDEN NAME Ninnie -----		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-12-2191		
17. INFORMANT AND ADDRESS Mrs. Rena Kaplan Lyon			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH 4 days		
Immediate cause 420.1 Coronary thrombosis					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a					
(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. no					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE			PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at m. Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from J.V. 11-23, 1951, to J.V. 11-27, 1951, that I last saw the deceased alive on J.V. 11-27, 1951, and that death occurred at 8:45 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
23. BURIAL, CREMATION REMOVAL (Specify)			NAME OF CEMETERY OR CREMATORIAL Hebrew Cemetery		
DATE REC'D BY LOCAL REG. June 29, 1951			LOCATION (City, town, or county) Halfway (State) Md.		
24. FUNERAL DIRECTOR Fred W. Kraiss			ADDRESS		
VS. A15			583111		

RECEIVED

JUL 1 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06365

Reg. Dist. No. 345

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>WASHINGTON MARYLAND</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND COUNTY FREDERICK</b>	
CITY (If outside corporate limits, write RURAL and OR, give nearest town) TOWN <b>SAN MAR.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>RURAL</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>FAHRNEY MEMORIAL HOME</b>		STREET ADDRESS <b>NEAR MIDDLETON</b>	
3. NAME OF DECEASED (Type or Print) <b>ESTA</b>	(First) <b>F.</b>	(Middle) <b>MC BRIDE</b>	4. DATE OF DEATH <b>JUNE 2 1951</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>APRIL - 27 - 1969 82-1-5 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE last birthday If under 1 year Months Days Hours Min. <b>82</b>
13. FATHER'S NAME <b>HENRY C. MC BRIDE</b>		11. BIRTHPLACE (State or foreign country) <b>NEAR MIDDLETON FRED. CO. MD. U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
17. INFORMANT AND ADDRESS <b>ELSWORTH. MC BRIDE 412 CROYDON ROAD</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SIGLER</b>	
18. MEDICAL CERTIFICATION <b>BALTIMORE - 12 - MD.</b>		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>Chronic Myocarditis - 5 yrs</b>	
21. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) How did injury occur?
OF INJURY m.		While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(COUNTY) (STATE)
22. I hereby certify that I attended the deceased from <b>March 10, 1950</b> , to <b>June 2, 1951</b> , that I last saw the deceased alive on <b>June 1, 1951</b> , and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above. SIGNATURE <b>John H. Bast</b> (Degree or title) <b>M.D.</b>		ADDRESS <b>Boonsboro</b>	DATE SIGNED <b>6/5/51</b>
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>June 5, 1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>LOCUST VALLEY CEMETERY NR. BURKETSVILLE MD.</b>
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <b>John H. Bast</b>	LOCATION (City, town, or county) (State) ADDRESS <b>W.M.F. BAST AND SONS BOONSBORO MD.</b>
24. FUNERAL DIRECTOR			

RECEIVED

BUREAU Y. S.

JUN 7 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06366

Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Leitersburg, Washington MARYLAND		County		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Leitersburg, Washington COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Leitersburg, Md		LENGTH OF STAY (in this place) 25 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Leitersburg, Washington County	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Raymond	(Last) McClellan	4. DATE OF DEATH June 9	(Month) (Day) (Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED (Specify) Married	8. DATE OF BIRTH Sept 7, 1887	9. AGE last birthday 64 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Frederick County, Md	
12. CITIZEN OF WHAT COUNTRY U.S.					
13. FATHER'S NAME George H. McClellan		14. MOTHER'S MAIDEN NAME Fanny Boone			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS Clara M. Foutz	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) Arterio sclerotic Cardio vascular Disease

10 yr +

## 422. I Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

N/A

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1946, to June 1951, that I last saw the deceased

alive on June 1951, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify)	DATE THEREOF June 12, 1951	NAME OF CEMETERY OR CREMATORIAL Lutheran	LOCATION (City, town, or county) Leitersburg	(State) Md.
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DATE REC'D BY LOCAL REG.	REG. NO.	REGISTRAR'S SIGNATURE Fred W. Powers	24. FUNERAL DIRECTOR ADDRESS Fred W. Kraiss, Hagerstown, Md.
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BURGESS U. S.

JUN 18 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06367

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown		STREET ADDRESS 229 1/2 N. Jonathan St. (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 229 1/2 N. Jonathan St.							
3. NAME OF DECEASED (First) Julia (Type or Print)		(Middle) none		(Last) Morris		4. DATE OF DEATH June 24 1951	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 5-3-1874	9. AGE last birthday 77 yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Birmingham, Ala.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Emily Stevenson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Emily O. Dudley, Hagerstown			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Vascular hypertension</i> 331X Antecedent cause(s) (b) <i>Cerebral Hemorrhage</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 83a (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE <i>Robert Wells Jr.</i>	(Degree or title) DEPUTY MEDICAL EXPRESS WASH. CO., MD.	DATE SIGNED 115 N. Potowmack St. Hagerstown, Md. 6/27/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6-27-51	NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown, Md. (State)
DATE REC'D BY LOCAL REG. Jan 27, 1957	REGISTRAR'S SIGNATURE <i>Shayle F. Stevens</i>	24. FUNERAL DIRECTOR John R. Watson Jr. Hagerstown, Md.	ADDRESS

DECEMBER  
JUN 29 1951  
BUREAU U.S.

M

116

Dr. Brewer

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06368

Reg. Dist. No. 303

## CERTIFICATE OF DEATH

1. PLACE OF DEATH CITY <b>Washington</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN Clearspring</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>TOWN Clearspring</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Main St.</b>		STREET ADDRESS <b>Main St.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>OTHO</b>	(Middle) <b>PRESTON</b>	(Last) <b>MYERS</b>
4. DATE OF DEATH	(Month) <b>June</b>	(Day) <b>6</b>	(Year) <b>1951</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>11/12/1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>	9. AGE last birthday <b>68 yrs.</b>
11. BIRTHPLACE (State or foreign country) <b>Clearspring, Ma.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>David Myers</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT AND ADDRESS <b>Norman W. Myers, Harrisburg, Penna.</b>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <b>420.1</b>		<b>Coronary Thrombosis &amp;</b> <b>Occlusion</b>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>94a</b>		<b>1 year</b>	
(a)			
(b)			
(c)		<b>Hyperensive Sclerosis</b> <b>5 years</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>May 15, 1950</b> , to <b>June 6, 1951</b> , that I last saw the deceased alive on <b>June 4, 1951</b> , and that death occurred at <b>5 A.m.</b> from the causes and on the date stated above. SIGNATURE <b>David Brewer M.D.</b>		ADDRESS <b>Clear Spring Md. 6/7/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6/8/51</b>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <b>Little Rose Hill Cem. Clearspring, Maryland</b>		(State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <b>D.W. Murray</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Andrew K. Coffman Hagerston Md.</b>			
VS A15		DATE <b>June 8, 1951</b>	

REFUGEE

BUREAU U.S.  
MAY 1951

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06369

Reg. Dist. No. 302

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Washington County Hospital		STREET ADDRESS 20 E. Washington St. (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Lynwood	(Middle) M	(Last) Newcomer
4. DATE OF DEATH June 3 1951	5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH Oct. 13, 1916	9. AGE last birthday 34 yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patrolman		10b. KIND OF BUSINESS OR INDUSTRY City Police Force	
13. FATHER'S NAME Charles A. Newcomer		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		12. CITIZEN OF WHAT COUNTRY? U.S.	
16. SOCIAL SECURITY NO. W. W. # 217-10-0636		17. INFORMANT Mrs. Janet J. Newcomer	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
914.5 Immediate cause (a) Electrocution			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 193 (b)		asphyxia by electrocution	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.	PLACE (Home, farm, factory, street, offce, bldg., etc.) INJURY Virginia Ave.		(CITY OR TOWN) Hagerstown (COUNTY) Washington (STATE) Md.
TIME (Month) (Day) (Year) OF INJURY 6 - 3 - 51 9:25	INJURY OCCURRED While at work Not white at work		HOW DID INJURY OCCUR? Came in contact with high tension wire
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE S. Police & Wells, MD.		(DEPUTY) MEDICAL EXAM. ADDRESS 1157 Patoniac Hagerstown, Md. 6-4-51	DATE SIGNED
WASH. CO., MD.			
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6/6/51	NAME OF CEMETERY OR CREMATOR Y Last Haven Cemetery	LOCATION (City, town, or county) Hagerstown, Md. (State)
DATE REC'D BY LOCAL REG. James (1951)	REG. G. Bowers	24. FUNERAL DIRECTOR ADDRESS W. J. Horowitz, Hagerstown, Md.	
773936			

BUREAU V. S.

JUN 7 1951

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06370

## CERTIFICATE OF DEATH

Reg. Dist. No.

306

1. PLACE OF DEATH CITY, TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS			MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY, TOWN STREET ADDRESS			COUNTY Harford				
3. NAME OF DECEASED (Type or Print)			(First) <i>Jacob</i>	(Middle) <i>Henry</i>	(Last) <i>Norton</i>	4. DATE OF DEATH			(Month) <i>June</i>	(Day) <i>1</i>	(Year) <i>1951</i>		
5. SEX			<i>M</i>	COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH			<i>May 8, 1902</i>	9. AGE last birthday If under Months. <i>49</i>	10. BUSINESS OR INDUSTRY <i>Rail Road</i>	11. BIRTHPLACE (State or foreign country) <i>Harford Co</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. INFORMANT AND ADDRESS			14. MOTHER'S MAIDEN NAME <i>Martha Waters</i>				
<i>Laborer</i>													
13. FATHER'S NAME <i>Jacob H. Norton</i>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <i>216-07-1959</i>			17. INFORMANT AND ADDRESS <i>Hospital Record</i>							
<i>Unknown</i>													

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause  
*Squamous cell Carcinoma*(a) *esophagus c metastasis* ~ 3 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last  
*Malnutrition*

(b) \_\_\_\_\_

(c) \_\_\_\_\_

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION      19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *May*, 1951, to *June*, 1951, that I last saw the deceased alive on *June 1*, 1951, and that death occurred at *6:20 A.M.* from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Axel A. Pace, M.D. Ritchie State Hospital, Cascades, Md. 6/1/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>6/15/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Asbury</i>	LOCATION (City, town, or county) <i>Joppa, Harford Md.</i>	(State)
DATE REC'D BY LOCAL REG. O	REGISTRAR'S SIGNATURE <i>Geo. W. Ferguson</i>	24. FUNERAL DIRECTOR <i>Howard R. McCormac &amp; Son</i>	ADDRESS <i>Abingdon Md. 910506</i>	

RECEIVED  
JUN 8 1952

BUREAU K.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06371

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland		COUNTY Washington	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Hagerstown		Life		TOWN Hagerstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Co. Hospital				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (First) Carrie		(Middle) E.		4. DATE OF DEATH June 2		(Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 7-27-1898	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday 52 yrs.		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland	
13. FATHER'S NAME George F. Sottlemeyer		14. MOTHER'S MAIDEN NAME Amanda Whitmore		12. CITIZEN OF WHAT COUNTRY U.S.A.			
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT AND ADDRESS Charles A. Pearl, Hagerstown, Md.		18. MEDICAL CERTIFICATION <i>Coronary Thrombosis</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause		(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Hypertension, Caro. Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 5-25-51	
260X 61		(c) Diabetes Mellitus					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 2, 1948</i> , to <i>June 2, 1951</i> , that I last saw the deceased alive on <i>June 1, 1951</i> , and that death occurred at <i>2:15 P.M.</i> , from the causes and on the date stated above. SIGNATURE <i>Sidney Novester M.D.</i> (Degree or title) <i>Hagerstown MD</i> DATE SIGNED <i>6-2-51</i>							
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6-5-1951		NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		LOCATION (City, town, or county) (State) Hagerstown, Maryland	
DATE REC'D BY LOCAL REG. <i>June 5, 1951</i>		REGISTRAR'S SIGNATURE <i>Robert Powers</i>		24. FUNERAL DIRECTOR C. M. Suter & Sons, Hagerstown, Md.		ADDRESS	

RECEIVED  
BUREAU V. S.

JUN 7 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06372

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and OR give nearest town) Maugansville LENGTH OF STAY TOWN 22 yrs. (This place)			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Maugansville		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Main St.			STREET ADDRESS Main St. (If rural, give location)		
3. NAME OF DECEASED (Type or Print)	(First) Mamie	(Middle) Flook	(Last) Petre	4. DATE OF DEATH	8 (Month) 6 - 17 (Day) 51 (Year)
5. SEX	6. COLOR OR RACE female white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH 5-7-1874	9. AGE last birthday 77 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Middletown, Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Jonas T. Flook			14. MOTHER'S MAIDEN NAME Annie m. Shoemaker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. - - -	17. INFORMANT AND ADDRESS George W. Petre, Maugansville, Md.		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

(a)

Coronary Occlusion

420.0 Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause  
93d stating the underlying cause last

(b)

Acute subacute Heart Disease

4 years

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) (Year) m.	(Hour) While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-1-1951, to 6-17-1951, that I last saw the deceased alive on 6-17-1951, and that death occurred at 1 P.M., from the causes and on the date stated above.  
 SIGNATURE ADDRESS DATE SIGNED  
*J. Scott Powers* *Hagerstown, Md.* *6/17/51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF 6-20-51	NAME OF CEMETERY OR CREMATORIAL Long Meadows Church	LOCATION (City, town, or county) Paramount, Md. (State)
DATE REC'D BY LOCAL REG.	REG. NO. 20, 51	REGISTRAR'S SIGNATURE <i>Scott Powers</i>	24. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son, Hagerstown

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JUN 22 1951

BUREAU K.S.



REF ID: A6542

BUREAU U.S.

JUN 11 1957

Dr. William Layman

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06374

Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		COUNTY <b>Washington</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Hagerstown</b>		LENGTH OF STAY (in this place) <b>1 month</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>		STREET ADDRESS <b>304 S. Mulberry St.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Washington Cty. Hospital</b>							
3. NAME OF DECEASED (Type or Print) <b>Elizabeth</b>		(First) (Middle) (Last) <b>Ann</b> <b>Pruett</b>		4. DATE OF DEATH <b>June 14, 1951</b>		(Month) (Day) (Year)	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>single</b>		8. DATE OF BIRTH <b>Mar 12 - 1951</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		9. AGE last birthday <b>2 yrs.</b>		If under 1 year Months Days Hours Min.	
13. FATHER'S NAME <b>Thomas E. Pruett</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
				17. INFORMANT AND ADDRESS <b>Thomas E. Pruett</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
18. MEDICAL CERTIFICATION 304 S. Mulberry St							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  491X Immediate cause (a) <i>Bronchial pneumonia</i> 107 Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Prematurity</i>							
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION							
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
While at m.		Not While Work At work		HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>May 12, 1951</i> , to <i>Jun 14, 1951</i> , that I last saw the deceased alive on <i>June 13, 1951</i> , and that death occurred at <i>7:35 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>W. J. Layman, M.D.</i> ADDRESS <i>5 Public Sqw Hagerstown, Md.</i> DATE SIGNED <i>Jun 18, 1951</i>							
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-15-1951</b>		NAME OF CEMETERY OR CREMATORIUM <b>Rest Haven Cemetery</b>		LOCATION (City, town, or county) <b>Hagerstown, Md.</b> (State)	
DATE REC'D BY LOCAL REG. <b>June 15, 1951</b>		REGISTRAR'S SIGNATURE <i>Lester Powers</i>		24. FUNERAL DIRECTOR <b>Andrew K. Coffman, Hagerstown, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully.  
The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AMY

RECEIVED

JUN 18 1952

BUREAU K.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06375

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>TOWN BREATHEDSVILLE</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <b>TOWN BREATHEDSVILLE (RURAL)</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>BOONSBORO MD. R.I.</b>		STREET ADDRESS <b>BOONSBORO MD. ROUTE 1</b>	
3. NAME OF DECEASED (Type or Print) <b>OLIVE G. REID</b>	(First) (Middle)	(Last)	4. DATE OF DEATH <b>JUNE - 17 1951</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY - 8 - 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE last birthday <b>70-1-9 yrs.</b>
13. FATHER'S NAME <b>WILLIAM H. McNAMEE</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE CROSS</b>	12. CITIZEN OF WHAT COUNTRY? <b>BREATHEDSVILLE WASH. CO. MD. U.S.A.</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT AND ADDRESS <b>WM. H. McNAMEE BOONSBORO MD R.I.</b>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>Acute Coronary Occlusion</b> 3 days Antecedent cause(s) (b) <b>Arterial Sclerotic Heart Disease.</b> ? Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m. Not While At work □	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>June 15, 1951</b> , to <b>June 17, 1951</b> , that I last saw the deceased alive on <b>June 15, 1951</b> , and that death occurred at <b>8.00A.m.</b> , from the causes and on the date stated above. SIGNATURE <i>J. Hubert Wade.</i> (Degree or title) <b>M.D.</b> ADDRESS DATE SIGNED <b>6/18/51</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>JUNE 19-1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>ST. MARKS CEMETERY</b>	LOCATION (City, town, or county) <b>LAPPANS WASH. CO. MD</b> (State)
DATE REC'D BY LOCAL REG. <b>JUN 19 1951</b>	REG. <b>John T. Bant</b>	REG.	REG.
24. FUNERAL DIRECTOR ADDRESS <b>W.M.F.BAST AND SONS BOONSBORO MD.</b>			

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JUN 22 1951

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06376

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: COUNTY Washington		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Hagerstown TOWN		LENGTH OF STAY (In this place) 62 yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Fountain Head Heights		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown	
3. NAME OF DECEASED (First) William (Type or Print)		(Middle) Harry Reisner Sr. (Last)	
4. DATE OF DEATH June 15 1951			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED (Specify) Married	8. DATE OF BIRTH Jan. 7, 1865
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacture		10b. KIND OF BUSINESS OR INDUSTRY Organ Supplies	11. BIRTHPLACE (State or foreign country) Mercesburg Penn.
13. FATHER'S NAME George Reisner		14. MOTHER'S MAIDEN NAME Ann C. Eckard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9387	
17. INFORMANT AND ADDRESS William H. Reianer Jr. Hag. Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 442X		(a) _____ <i>Cardio-Renal Disease</i>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 131a stating the underlying cause last		(b) _____ <i>Arterosclerosis</i>	
		(c) _____ <i>Cardiac Failure</i>	
INTERVAL BETWEEN ONSET AND DEATH 1949. 1943 5 days.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION —	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from <u>10-15-</u> , 19 <u>51</u> , to <u>June 15, 1951</u> , that I last saw the deceased alive on <u>June 14, 1951</u> , and that death occurred at <u>4: 40a</u> m., from the causes and on the date stated above. SIGNATURE <u>W. Howard George, M.D.</u> ADDRESS <u>June 15, 1951.</u> DATE SIGNED <u>June 15, 1951.</u>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 17-51	
NAME OF CEMETERY OR CREMATORIAL Cove Valley		LOCATION (City, town, or county) McConnellsburg Penn. (State)	
DATE REC'D BY LOCAL REG. June 17, 1951		REGISTRAR'S SIGNATURE <i>Howard George</i>	
24. FUNERAL DIRECTOR Scott F. Minnich & Son Hag. Md.		ADDRESS	

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JUN 19 1957

BUREAU X-5

# MARYLAND STATE DEPARTMENT OF HEALTH

06377

**2411 N. Charles Street, Baltimore**

## CERTIFICATE OF DEATH

**Reg. Dist. No**

302

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly. The correct age

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JUL 1 1951

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06378

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Washington MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wash.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hagerstown LENGTH OF STAY (in this place) 2 1/2 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Hancock STREET (If rural, give location) ADDRESS West Main Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Wash. Co. Hospital		3. NAME OF DECEASED (First) Maxwell (Middle) (Last) Richards 4. DATE OF DEATH JUNE 28, 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1-31-70 9. AGE last birthday 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANKER - at First National Bank		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Isaac Richards		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mabel Brooks Richards (wife)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause 15X (a) Carcinoma of stomach Antecedent cause(s) 466 (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 466 (c) General arterio-sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION Apr. 24, 1951		19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/> Not While <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Apr. 1, 1951, to June 28, 1951, that I last saw the deceased alive on June 27, 1951, and that death occurred at 7 a.m., from the causes and on the date stated above. SIGNATURE R.S. Stauffer (Degree or title) ADDRESS Hagerstown, Md. DATE SIGNED June 28, 1951			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 6-30-51 NAME OF CEMETERY OR CREMATORIUM Presbyterian Cem. LOCATION (City, town, or county) Hancock, Md. (State)	
DATE REC'D BY LOCAL REG. June 29, 1951		REG. ST. REGISTRAR'S SIGNATURE Charles R. Best, Hancock, Md. ADDRESS 290716	
24. FUNERAL DIRECTOR			

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JUL 1951

**BUREAU Y. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06379

## CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH COUNTY <u>Washington</u>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Pennsylvania</u>		COUNTY <u>Franklin</u>
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Cascade</u>		LENGTH OF STAY (in this place) <u>2 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Blue Ridge Summit</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ritchie State Hosp.</u>		SUBDIVISION ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <u>Guy</u>	(Middle) <u>Alvey</u>	(Last) <u>Ridensour</u>	4. DATE OF DEATH	(Month) <u>June</u> (Day) <u>10</u> (Year) <u>1957</u>
5. SEX	<u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb. 22, 1887</u>	9. AGE last birthday <u>64</u> If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tremont</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Deerfield, Maryland</u>	
13. FATHER'S NAME <u>Washington Ridensour</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Umbrose</u>		12. CITIZEN OF WHAT COUNTRY? <u>A.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>209-12-6043</u>		17. INFORMANT AND ADDRESS <u>Hospital Record &amp; Family</u>	

18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <u>162X</u>		(a) <u>Bronchogenic Carcinoma of the lung c metastasis.</u>			
Antecedent cause(s) <u>47C</u>		(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		(c) <u>status post pneumonectomy</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>June 9, 1957</u> , to <u>June 10, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>7:30 P.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Reel A. Laar, M.D.</u>		(Degree or title) <u>Bethel Church Cemetery</u>		ADDRESS <u>Washington Co. Md.</u>	
DATE SIGNED <u>6/10/57</u>		NAME OF CEMETERY OR CREMATORIAL <u>Bethel Church Cemetery</u>		LOCATION (City, town, or county) <u>Washington Co. Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>6/13/1957</u>		(State) <u>Pa.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>Geo. H. Ferguson</u>		24. FUNERAL DIRECTOR <u>Haynesboro</u>	
ADDRESS <u>Fairfax, Va.</u>				ADDRESS <u>Pa.</u>	



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JUN 14 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06380

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>		COUNTY <i>Washington</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hagerstown</i>		LENGTH OF STAY (in this place) <i>7 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Williamsport</i>		STREET ADDRESS <i>R. R. # 25</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington County Hospital</i>							
3. NAME OF DECEASED (Type or Print) <i>Allen Walter Shank</i>		(First)	(Middle)	(Last)	<i>Twin</i>	4. DATE OF DEATH <i>June 6 1951</i>	(Month) (Day) (Year)
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>single</i>	8. DATE OF BIRTH <i>June 5, 1951</i>	9. AGE last birthday yrs. <i>0</i>	If under Months. <i>0</i>	1 year Days <i>20</i>	If under 24 hrs. Hours <i>28</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>United States</i>	12. CITIZEN OF WHAT COUNTRY <i>America</i>			
13. FATHER'S NAME <i>Harold Lighter Shank</i>		14. MOTHER'S MAIDEN NAME <i>Rosalie Jacqueline Mcleish</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mother</i>				

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

*Prematurity - 28 weeks gestation*

## 776X Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last*97 intrauterine death of the other twin -  
Cause unknown.*II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *birth*, 19....., to *6/6*, 1951, that I last saw the deceased alive on *6/5*, 1951, and that death occurred at *9:48 A.M.*, from the causes and on the date stated above.

SIGNATURE *Walter H. Shank M.D.*(Degree or title) *Shankabus M.D.*DATE SIGNED *June 6, 1951*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>June 8, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Greenlawn Cemetery</i>	LOCATION (City, town, or county) <i>Williamsport Md.</i>
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DATE REC'D BY LOCAL REG. <i>June 8, 1951</i>	REG. <i>6 Post Office</i>	REG. <i>Albert L. Self Williamsport Md.</i>
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REG. <i>6 Post Office&lt;/i</i>
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RECEIVED

JUN 11 1951

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Dr. Bell

06381

Reg. Dist. No. 302

## CERTIFICATE OF DEATH

1. PLACE OF DEATH CITY <b>Washington</b>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Hagerstown</b>			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hagerstown</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>245 E. Irvin Ave.</b>			STREET ADDRESS <b>245 E. Irvin Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>Lela</b>			(Last) <b>Simmers</b>			
4. DATE OF DEATH <b>June 12, 1951</b>	(Month)	(Day)	(Year)			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Dec. 14, 1874</b>	9. AGE last birthday <b>76</b>	If under 1 year Months	If under 24 hrs. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Welsh Run, Penna.</b>		
13. FATHER'S NAME <b>James Brewer</b>			14. MOTHER'S MAIDEN NAME <b>Betty Brewer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT AND ADDRESS <b>Wanda Simmers</b>		
18. MEDICAL CERTIFICATION <b>245 E. Irvin Ave.</b>						INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
Immediate cause <b>420.1</b> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>93d</b>						(a) arteriosclerotic myocardial heart disease
						(b) acute coronary occlusion
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>arthritis</b>						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>			(CITY OR TOWN) <b>Hagerstown</b>	(COUNTY) <b>Md.</b>
(Specify)					(STATE) <b>MD.</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>Sudden death</b>			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.						
SIGNATURE <b>S. Robert &amp; Wells MD</b> DEPUTY MEDICAL EXAMINER ADDRESS <b>Hagerstown, Md., 6-14-51</b> DATE SIGNED						
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-14-1951</b>	NAME OF CEMETERY OR CREMATORIAL <b>Green Hill Cemetery</b>	LOCATION (City, town, or county) <b>Greencastle, Pa.</b>	(State)	
DATE REC'D BY LOCAL REG. <b>June 14 1951</b>		REGISTRAR'S SIGNATURE <b>Short, Bowers</b>	24. FUNERAL DIRECTOR ADDRESS <b>Andrew K. Coffman, Hagerstown, Md.</b>			

RECEIVED

JUN 18 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06382

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY WASHINGTON			2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND COUNTY WASHINGTON		
CITY (If outside corporate limits, write RURAL and OR give nearest town) HAGERSTOWN			LENGTH OF STAY (in this place) 35 YRS.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS WASHINGTON COUNTY HOSPITAL			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAGERSTOWN		
3. NAME OF DECEASED (First) CARRIE (Type or Print)			4. DATE OF DEATH JUNE 17 1951		
(Middle) MAY			(Month) (Day) (Year)		
(Last) SMITH					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify) MARRIED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRONER		10b. KIND OF BUSINESS INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RICHARD CHARLES KLINE		14. MOTHER'S MAIDEN NAME LOLA CATHERINE KLINE		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-09-9072		17. INFORMANT AND ADDRESS MR. CHARLES W. SMITH HAG. MD.	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause

AdenoCarcinoma of uterus, metastasis to lung

1 yr.

174X Antecedent cause(s)

Diseases or conditions, if any, (b) \_\_\_\_\_

giving rise to the above cause  
stating the underlying cause last

(c) \_\_\_\_\_

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
OF INJURY	m.					

22. I hereby certify that I attended the deceased from June 16, 1950, to June 17, 1951, that I last saw the deceased

alive on June 16, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Robert V. Campbell (MD) 145 W. Washington St. Hagerstown, Md. 6/18/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 6/19/51	NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	LOCATION (City, town, or county) Hagerstown	(State) Md.
DATE REC'D BY LOCAL REG. June 18, 1951		REGISTRAR'S SIGNATURE Charles A. Powers	24. FUNERAL DIRECTOR W. J. Horowitz		
			ADDRESS		

Dr. Robert Campbell

9<sup>30</sup>  
am.

145 W. Washington St.

BUREAU A. S.

JUN 20 1951

RECEIVED



RECEIVED

JUN 12 1951

BUREAU V. S.



RECEIVED

JUN 20 1951

BUREAU U.S.

Dr. R. Campbell

06385

Reg. Dist. No. 302

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

COUNTY

Washington

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)LENGTH OF STAY  
(in this place)

TOWN Hagerstown

1 Week

HOSPITAL OR

INSTITUTION OR

STREET ADDRESS Washington Co. Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Washington

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Hagerstown

STREET

ADDRESS

(If rural, give location)

1324 Fairchild Ave.

## 3. NAME OF

(First)

(Middle)

(Last)

DECEASED

(Type or Print)

ANNE

MARGARET

STAKEM

4. DATE

OF

DEATH

June

15

19

51

## 5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED (Specify)

8. DATE OF BIRTH

Nov. 10, 1880

9. AGE last birthday

66 yrs.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Government Clerk

10b. KIND OF BUSINESS OR  
INDUSTRY

Office

11. BIRTHPLACE (State or foreign country)

Coudersport,

Penns.

12. CITIZEN OF WHAT  
COUNTRY? USA

## 13. FATHER'S NAME

John Tonko

## 14. MOTHER'S MAIDEN NAME

Mary Guydos

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of  
service)

16. SOCIAL SECURITY NO.

277-22-8831

## 17. INFORMANT AND ADDRESS

Mrs Margaret Downey, Hagerstown Md

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Cerebral Thrombosis

INTERVAL BETWEEN  
ONSET AND DEATH

24 hr

260X

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

61

(c)

Arteriosclerosis

Hypertension, Diabetes mellitus

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

## 21. ACCIDENT (Specify)

SUICIDE

HOMICIDE

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED  
While at Work  Not While At work 

HOW DID INJURY OCCUR?

m.

5:15 A.m.

DATE SIGNED

22. I hereby certify that I attended the deceased from June 12, 1951, to June 15, 1951, that I last saw the deceased

alive on June 14, 1951, and that death occurred at 5:15 A.m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

Robert W. Campbell MD

Hagerstown MD June 25, 1951

23. BURIAL, CREMATION  
REMOVAL (Specify)

Removal

DATE REC'D BY LOCAL  
REG.

REG.

DATE THEREOF

6/17/51

St. Pauls Cemetery

NAME OF CEMETERY OR CREMATORIUM

Euclid

Ohio

ADDRESS

REG.

RECEIVED

JUN 20 1951

BUREAU Y.

JUN 20 1951

RECEIVED

JUN 20 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

06386

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Wash.		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Hagerstown		LENGTH OF STAY 15 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown		STREET ADDRESS (If rural, give location) 310 N. Locust St.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS 310 N. Locust St.								
3. NAME OF DECEASED (Type or Print)	(First) Clinton	(Middle) A.	(Last) Stouffer	4. DATE OF DEATH 6/11/51		(Month) 6	(Day) 11	(Year) 1951
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed	8. DATE OF BIRTH I/28/1862	9. AGE last birthday 89 yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours	If under 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY Roller Organ	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Levi Stouffer		14. MOTHER'S MAIDEN NAME Margaret Lockler						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 10 3430		17. INFORMANT AND ADDRESS Mrs. Grace Baylor		Hagers.		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *artery sclerosis myocard heart disease 15 yrs*

420.1 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
93d  
stating the underlying cause last(b) *Coronary Thrombosis*

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 6/11/51, 19....., to 6/15/51, 19....., that I last saw the deceased alive on 6/15/51, 19....., and that death occurred at 11:20 A.M. from the causes and on the date stated above.  
 SIGNATURE J. D. Stouffer ADDRESS Hagerstown Md. DATE SIGNED 9/3/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 6/14/51	NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	LOCATION (City, town, or county) Hagerstown, Md.	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>Grace Powers</i>	FUNERAL DIRECTOR F.W. Kraiss	ADDRESS Hagerstown, Md.	

RECEIVED

JUN 18 1951

BUREAU WASH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06387

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Washington				Maryland COUNTY Washington	
CITY (if outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY		CITY (if outside corporate limits, write RURAL and give nearest town)	
Hagerstown		One week		OR TOWN Hagerstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Washington Co. Hospital		STREET ADDRESS (If rural, give location)	
218 Summer St					
3. NAME OF DECEASED (Type or Print)		(First) George	(Middle) William	(Last) Swartz	4. DATE OF DEATH June 1, 1951
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday Feb. 1901 80 yrs.
Male		White			If under 1 year Month Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
(Retired) Conductor		J. Md. R. R. Co.		Clark Co. Va. 12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME		Clara E. Albright			
Augustus Swartz					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
				Mrs. Hannah R. Swartz	
18. MEDICAL CERTIFICATION					

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

Immediate cause (a) Hypertensive cardiovascular disease. Years

443X Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

93d (b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senile dementia

6 mos.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
		INJURY			

TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED OF INJURY	HOW DID INJURY OCCUR?
				While at Work m.	Not While At work <input type="checkbox"/>

22. I hereby certify that I attended the deceased from July 19, 1951, to June 1, 1951, that I last saw the deceased alive on May 31, 1951, and that death occurred at 2:07 A.M., from the causes and on the date stated above.  
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Kraiss M.D. Hagers own, Maryland June 2, 1951.

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
Burial	June 3, 1951	Rest Haven Cem.	Hagerstown, Md.	

DATE REC'D BY LOCAL REG.	REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 3, 1951		Blair Powers	Kraiss Funeral Home	Hagerstown,

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JUN 6 1951

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct  
is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06388

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Hagerstown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairplay</u>		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>							
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>OSCAR</u>	(Last) <u>SWARTZ</u>	4. DATE OF DEATH	(Month) <u>June</u>	(Day) <u>6</u>	(Year) <u>1951</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs Days	If under 24 hrs Hours
<u>Male</u>	<u>white</u>	<u>3/16/76</u>	<u>75</u>	yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Clark Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Swartz</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Gordon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-7498</u>	
17. INFORMANT AND ADDRESS <u>Grover C. Swartz Hagerstown Md</u>		18. MEDICAL CERTIFICATION <u>Coronary Occlusion</u>		19. DATE OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>420.1</u>		(a) _____					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <u>94a</u> stating the underlying cause last		(b) _____					
		(c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work	Not While At work	HOW DID INJURY OCCUR?	
OF INJURY	m.						
22. I hereby certify that I attended the deceased from <u>5/16/51</u> , 19....., to <u>6/6/51</u> , 19....., that I last saw the deceased alive on <u>5/16/51</u> , 19....., and that death occurred at <u>11:30 P.M.</u> , from the causes and on the date stated above.		SIGNATURE <u>John Young Jr. M.D.</u>		ADDRESS <u>William J. Young</u>		DATE SIGNED <u>6/7/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>		DATE THEREOF <u>6/10/51</u>		NAME OF CEMETERY OR CREMATORIAL <u>Rose Hill Cemetery</u>		LOCATION (City, town, or county) <u>Hagerstown</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. <u>June 8, 1951</u> <u>Robert Boevers</u>		24. FUNERAL DIRECTOR ADDRESS					

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06389

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	STREET ADDRESS (If rural, give location)
TOWN <u>Hagerstown</u>		TOWN <u>Hagerstown</u>	<u>517 Jefferson St.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Washington Co. Hospital</u>			
3. NAME OF DECEASED (Type or Print) <u>DANIEL E. THOMPSON III</u>	(First) <u>DANIEL</u>	(Middle) <u>E.</u>	(Last) <u>THOMPSON III</u>
4. DATE OF DEATH <u>June 28</u>	(Month) <u>June</u>	(Day) <u>28</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 13 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday If under 1 year Months <u>1</u> Days <u>0</u> If under 24 hrs. Hours <u>0</u> Min. <u>0</u>	11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>
13. FATHER'S NAME <u>Daniel E. Thompson Jr.</u>	14. MOTHER'S MAIDEN NAME <u>Luretta Mae Mc Kinsey</u>	12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEDER EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT AND ADDRESS <u>Daniel Edward Thompson Jr.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATHImmediate cause 760.0(a) Intra cranial Hemorrhage3 days

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(b) Cause not determined

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) (Year) m.	(Hour) While at Work <input type="checkbox"/> At work <input type="checkbox"/>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 26, 1957, to June 28, 1957, that I last saw the deceasedalive on June 28, 1957, and that death occurred at 311 m., from the causes and on the date stated above.SIGNATURE D W DethADDRESS Hagerstown MdDATE SIGNED 6/29/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/30/57</u>	NAME OF CEMETERY OR CREMATORIAL <u>Rest Haven Cemetery</u>	LOCATION (City, town, or county) <u>Hagerstown Md</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>June 29 1957</u>	REG. NO. <u>Short Shower</u>	24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>	ADDRESS <u>Hagerstown Md</u>	

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JUL 1 1951

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06390

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <b>Washington</b>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Hagerstown</b>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Funkstown</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Garlock Nursing Home			STREET ADDRESS <b>Beaver Creek Road</b>		
3. NAME OF DECEASED (Type or Print) <b>ALICE REED</b>			4. DATE OF DEATH <b>June 19 1951</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Oct. 27, 1866</b>	9. AGE last birthday <b>84 yrs.</b>	If under 1 year Months   Days   Hours   Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Funkstown, Wash Co., Md.</b>	
13. FATHER'S NAME <b>Joseph Reed</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT AND ADDRESS <b>Hugh Troxell, Hagerstown, Md.</b>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

*Cerebral Thrombosis*INTERVAL BETWEEN  
ONSET AND DEATH

6-3-51

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b)

*Hyperpertensive condit - Vasculon disease*

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR? Not While At work	
OF INJURY	m.				

22. I hereby certify that I attended the deceased from **June 3, 1951**, to **June 9, 1951**, that I last saw the deceased  
alive on **June 19, 1951**, and that death occurred at **9 P.M.**, from the causes and on the date stated above.  
SIGNATURE **Sedney Novester MD** ADDRESS **Funkstown Md** DATE SIGNED **6-20-51**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>6/21/51</b>	NAME OF CEMETERY OR CREMATORIAL <b>Funkstown Cemetery</b>	LOCATION (City, town, or county) (State) <b>Funkstown Maryland</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <b>John W. Bowers</b>	24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>	ADDRESS <b>Hagerstown, Md.</b>

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JUN 22 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

06391

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 3010

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Cascade</u>		LENGTH OF STAY (in this place) <u>1 1/2 yrs.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Hospital</u>		STREET ADDRESS <u>RFD # 4</u>	
3. NAME OF DECEASED (Type or Print) <u>Fannie</u>		(First) <u>Kate</u> (Middle) <u>Turner</u> (Last)	
4. SEX <u>F</u>	5. COLOR OR RACE <u>W</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	7. DATE OF BIRTH <u>Dec. 3, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13. FATHER'S NAME <u>Isaiah Showe</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
16. SOCIAL SECURITY NO. <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Rhodenizer (Harriett Ellen)</u>	
17. INFORMANT AND ADDRESS <u>Hospital Record</u>		18. MEDICAL CERTIFICATION <u>Adeno carcinoma of cervix of uterus</u> 6 yrs.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  1. Immediate cause <u>171X</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>48a</u> (a) (b) (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u> may yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec. 9</u> , 1949, to <u>June 2</u> , 1951, that I last saw the deceased alive on <u>June 2</u> , 1951, and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. SIGNATURE <u>Daniel Lai</u> ADDRESS <u>m.d. Ridgeway Hospital, Cascade, Md.</u> DATE SIGNED <u>6/2/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>D.</u>		DATE THEREOF <u>6-5-51</u> NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <u>Bethelton Cemetery</u> <u>Hagerstown</u> (State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 4 1951</u>		REGISTRAR'S SIGNATURE <u>Rev. W. Ferguson</u> 24. FUNERAL DIRECTOR ADDRESS <u>Andrew K. COFFMAN Hagerstown</u> MD.	

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MAY 6 1951  
FBI - W. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

Dr. Ditto

06392

Reg. Dist. No. .... 302.

# CERTIFICATE OF DEATH

I. PLACE OF DEATH: COUNTY <b>Washington</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Hagerstown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>111 Winter St.</b>		STREET ADDRESS <b>111 Winter St.,</b> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>DAVID</b>	(First) <b>DAVID</b>	(Middle) <b>MARION</b>	(Last) <b>VANCE</b>
4. DATE OF DEATH <b>June 6</b>	(Month) <b>June</b>	(Day) <b>6</b>	(Year) <b>195</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>12/11/1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most working life even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	11. BIRTHPLACE (State or foreign country) <b>Welsh Run, Franklin Co., Pa.</b>
13. FATHER'S NAME <b>David E. Vance</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
		17. INFORMANT AND ADDRESS <b>Mrs Viola Vance, Hagerstown Md.</b>	

MARGIN RESERVED FOR BINDING

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V.S. A15

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JUN 11 1951

**BUREAU K-5**

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

06393

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <u>Washington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Penna.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY <u>Dayshire</u>
TOWN <u>Hazleton</u>	<u>1 month</u>	TOWN <u>Harrisburg</u>	(If rural, give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>34 High Street</u>	STREET ADDRESS <u>625 Dunkle St.</u>		
3. NAME OF DECEASED (Type or Print) <u>Edith M. Wallace</u>	(First) <u>Edith</u>	(Middle) <u>M.</u>	(Last) <u>Wallace</u>
4. DATE OF DEATH <u>6 19 1951</u>	(Month)	(Day)	(Year)
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb. 25 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>A.S.A.</u>
13. FATHER'S NAME <u>Charles Fleet</u>	14. MOTHER'S MAIDEN NAME <u>Sarah Lowry</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Ruth Keely - 34 High Street</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u>		<u>Arteriosclerotic myocardial heart</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>93d</u>		<u>disease</u> <u>acute coronary occlusion</u>	
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. <u>INJURY</u>	PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> SIGNATURE <u>S. Robert Nichols, M.D.</u> (Degree or title) <u>DEPUTY MEDICAL EXAM.</u> ADDRESS <u>115 N. Potomac</u> DATE SIGNED <u>6/20/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>6/20/51</u>	NAME OF CEMETERY OR CREMATORIUM <u>Rose Hill</u>	LOCATION (City, town, or county) <u>Hazleton, Md.</u>
DATE REC'D BY LOCAL REG. <u>June 20, 1951</u>	REG. <u>6/20/51</u>	REGISTRAR'S SIGNATURE <u>Robert Nichols</u>	24. FUNERAL DIRECTOR <u>J. W. Kraissel</u>
ADDRESS			

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JUN 22 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06394

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY Washington MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Washington		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Funkstown LENGTH OF STAY (In this place) 50 yrs.			CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Funkstown		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Beverly Manor			STREET ADDRESS (If rural, give location) Beverly Manor, No St. Address		
3. NAME OF DECEASED (Type or Print)	(First) Dollie	(Middle) Ann	(Last) Walters	4. DATE OF DEATH	(Month) June (Day) 5 (Year) 51
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours Min.
Female	White		11-20-1881	69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY		
			11. BIRTHPLACE (State or foreign country) Luray, Virginia		
13. FATHER'S NAME Joseph Huffman			14. MOTHER'S MAIDEN NAME Amanda C. Foltz		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. NONE		
17. INFORMANT AND ADDRESS Norman Walters, Hagerstown, Maryland			18. MEDICAL CERTIFICATION		

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

600.0 Immediate cause (a) Chronic Pyelonephritis with Uremia 4 years

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause

133a stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Anemia, Megacytic, Severe

3 years

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
m.					

22. I hereby certify that I attended the deceased from 2-13, 1947, to 6-5, 1951, that I last saw the deceased

alive on 6-5, 1951, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Salisbury, Md. 6-6-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county)	(State)
Burial	6-7-1951	Rose Hill Mausoleum	Hagerstown	Maryland

DATE REC'D BY LOCAL REG. #	REG. #	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
June 1951		Short Bowers	M. Suter & Sons, Hagerstown, Maryland	

Dr. W. E. T.

BUREAU U.S.  
REGISTRY  
UN & 1951

## MARYLAND STATE DEPARTMENT OF HEALTH

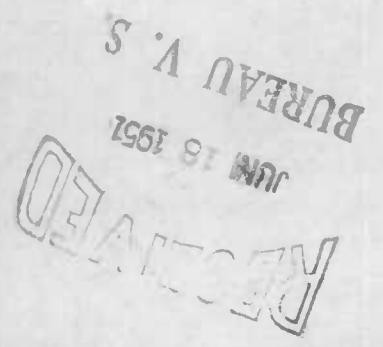
2411 N. Charles Street, Baltimore

06395

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <b>Washington</b>		MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <b>Hagerstown</b>		LENGTH OF STAY (in this place) <b>50 yrs.</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b>		COUNTY <b>Washington</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>77 Wise Street</b>						CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hagerstown</b>			
3. NAME OF DECEASED (Type or Print) <b>Ethel</b>		(First) (Middle) <b>Henrietta</b>		(Last) <b>Wiley</b>		4. DATE OF DEATH <b>June 13</b>		(Month) (Day) (Year) <b>19 51</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>		8. DATE OF BIRTH <b>4-25-1883</b>		9. AGE last birthday <b>68 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Taneytown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13. FATHER'S NAME <b>George Shoemaker</b>				14. MOTHER'S MAIDEN NAME <b>Laura Martin</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT AND ADDRESS <b>Mrs. Blanche Rockwell, Hagerstown, Md</b>		18. MEDICAL CERTIFICATION <i>Carcinoma of larynx</i> <i>Carcinoma of cervix - primary</i> <i>Chrom. Pulmonary Tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
17IX Immediate cause <b>Carcinoma of larynx</b>		(a) <b>Carcinoma of larynx</b>							
48a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Carcinoma of cervix - primary</b>		(b) <b>Carcinoma of cervix - primary</b>							
		(c) <b>Chrom. Pulmonary Tuberculosis</b>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>(6-26-51 ams)</b>									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
21. ACCIDENT SUICIDE HOMICIDE		(Specify) INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 23</b> , 1951, to <b>June 13</b> , 1951, that I last saw the deceased alive on <b>June 12</b> , 1951, and that death occurred at <b>7:00 a.m.</b> , from the causes and on the date stated above. SIGNATURE (Degree or title) <b>W. Howard George, M.D., Hagerstown, Md</b> ADDRESS <b>June 15, 1951</b> DATE SIGNED									
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-15-1951</b>		NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill Cemetery</b>		LOCATION (City, town, or county) <b>Hagerstown, Maryland</b>		(State)	
DATE REC'D BY LOCAL <b>June 15, 1951</b>		REG. <b>Stuart Shover</b>		REG. <b>Stuart Shover</b>		24. FUNERAL DIRECTOR <b>C. M. Suter &amp; Sons, Hagerstown, Maryland</b>		ADDRESS	



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